

Montana Central Tumor Registry

Newsletter



Using the Montana Central Tumor Registry to Describe the Cancer Burden among American Indians

Eliminating disparities in cancer incidence among Montana American Indians (MT AI) is a priority for the Montana Cancer Control Programs and the Montana Comprehensive Cancer Coalition, especially those cancers in which mortality can be reduced by early detection. Recently, the Montana Central Tumor Registry (MCTR) examined the incidence of cancer among MT AI to assist these organizations in program planning. The MCTR found that all-site cancer incidence was significantly greater among MT AI compared to MT White. Further investigation by cancer site found a disturbing trend in colorectal cancer (CRC) incidence among MT AI.

Few published studies have described CRC incidence among AI in Montana in recent years. The following abstract was submitted by the MCTR to the North American Association of Central Cancer Registries (NAACCR) 2014 Annual Conference.

Title: Early age and late stage diagnosis of colorectal cancer among American Indian residents of Montana, 2001-2010

Background: Montana (MT) is a frontier state with American Indians (MT AI) being the single largest non-white racial group in the state, accounting for 7% of the population. Colorectal cancer (CRC) is the third most frequently diagnosed cancer among AI and Whites in MT. CRC mortality can be reduced through universal CRC screening. In 2010, participation in CRC screening among MT adults was significantly lower among AI compared to Whites (41% and 57%; $P < 0.05$).

Purpose: This study describes CRC incidence among MT AI residents compared to MT White residents and U.S. American Indians and Alaska Natives (AI/AN).

Methods: Invasive colorectal cancers diagnosed from 2001 through 2010 in the MT Central Tumor Registry (MCTR) were analyzed by race (White or AI), age group (< 50, 50-64, ≥65), and stage at diagnosis (early [local] or late [regional and distant]). MT AI data were compared to the U.S. AI/AN with data from the National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program from 2000 through 2010.

Results: MT AI have significantly higher CRC age-adjusted incidence rates than MT Whites and SEER AI/AN (77.8/100,000, 44.8/100,000, 42.0/100,000, respectively). Late stage diagnosis was significantly greater among MT AI compared to MT Whites (65% compared to 56%; $P \leq 0.01$). The majority of MT AI cases were less than 65 years at diagnosis (57%) compared to MT White (34%). Late stage diagnosis in the 50-64 age group was significantly higher among MT AI compared to MT White and SEER AI/AN.

Conclusion: MT AI experienced CRC in younger age groups and at later stages of diagnosis compared to their MT White and SEER AI/AN counterparts. These data highlight the need for culturally appropriate population-based approaches to increase CRC screening in this population.

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Coding Biopsy vs. Surgery for Lymphoma

Source: Nov 2010 NAACCR webinar

Determining whether surgical procedures for lymphomas are considered a biopsy or a surgery code can be difficult. The MCTR staff have noticed that registrars often miscode procedures for lymphoma. Here's what we've learned:

- If the intent of the procedure was diagnostic, assign code 02 under Diagnostic Staging Procedure
- If the intent was treatment, use code 25 for Surgical Procedure of Primary Site

If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02 in Surgical Diagnostic and Staging Procedure field. If that node resected is the only node diagnosed with lymphoma, use the Surgical Procedure of the Primary Site code for the lymphoma primary - 25.

(I & R Team) 47421

4/29/2010

Source: Aug 2012 NAACCR webinar

Example 1

- A patient presents with bilateral cervical adenopathy. Two lymph nodes are surgically excised from the right side of the neck. These lymph nodes are positive for B-cell lymphoma. Excisional biopsy of the two lymph nodes would be coded as 02 (Diagnostic Staging Procedure).

Example 2:

- Patient with palpable cervical lymph node presents for excisional biopsy; staging workup failed to reveal any additional disease. Assign code 25 (surgical procedure of primary site).

Annual Report to the Nation: Lung Cancer Death Rates Continue to Fall

Source: CDC Weekly Digest Bulletin 12/17/13

The *Annual Report to the Nation on the Status of Cancer*, covering the period 1975–2010, showed death rates for lung cancer, which accounts for more than one in four cancer deaths, dropping at a faster pace than in previous years. The recent larger drop in lung cancer deaths is likely the result of decreased cigarette smoking prevalence over many years.

The lung cancer death rate decline, as well as declines in colorectal, breast, and prostate cancer death rates, has also helped drive decreases in death rates for all cancers types combined, a trend that began about 20 years ago. The decreased death rates for these four cancers accounted for more than two-thirds of the overall reduction in cancer death rates in the period 2001–2010. However, the report showed that death rates increased for some cancers, including cancers of the liver and pancreas for both sexes, cancers of the uterus in women,

and, in men only, melanoma of the skin and cancers of the soft tissue in this 10-year period. During the period of 2001–2010, overall cancer incidence rates decreased by 0.6 percent per year among men, were stable among women, and increased by 0.8 percent per year among children (ages 0 through 14 years), continuing trends from recent reports.

The special feature of [this year's report](#) highlights the prevalence of other disease conditions, (diabetes, chronic lung disease, cardiovascular disease, and 13 others) in cancer patients over 65 years of age, and how they affect survival. As in previous years, this year's study was conducted by the Centers for Disease Control and Prevention in collaboration with the American Cancer Society, the National Cancer Institute, and the North American Association of Central Cancer Registries.

Screening for Lung Cancer

The U.S. Preventive Services Task Force (Task Force) has issued a **final** recommendation statement on *Screening for Lung Cancer*. This final recommendation statement applies to adults who have no signs or symptoms of lung cancer but who are at high risk for developing the disease because of their age and smoking history. The final recommendation statement summarizes what the Task Force learned about the potential benefits and harms of screening for lung cancer: Adults between 55 and 80 years old who are at high risk for lung cancer because they are current heavy smokers or have quit within the past 15 years should be screened every year with a test called low-dose computed tomography.

For more information about the Task Force's recommendation visit <http://www.uspreventiveservicestaskforce.org/uspstf/uspplung.htm>

Save the Date

Montana Cancer Registrars Association Spring Meeting

May 8-9, 2014

Fairmont Hot Springs

Certificate of Excellence Recipients

The following facilities received a certificate for the 2013 Third Quarter, acknowledging their timeliness in reporting.

<u>Facility</u>	<u>City</u>
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Physicians:

Rogers Dermatology
Advanced Dermatology of Butte
Dermatology Assoc of Great Falls
Associated Dermatology
Dermatology Associates

Bozeman
Butte
Great Falls
Helena
Kalispell

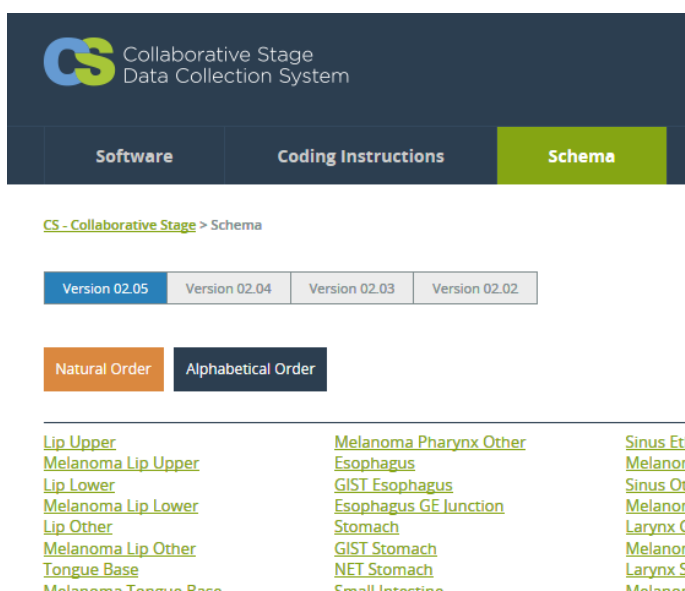
Hospitals:

Big Sandy Medical Center
Billings Clinic
St. Vincent Healthcare
St. James Healthcare
Teton Medical Center
MT VAMC
Sletten Cancer Center
Kalispell Regional Medical Center
Central Montana Medical Center
St. Patrick Hospital

Big Sandy
Billings
Billings
Butte
Choteau
Fort Harrison
Great Falls
Kalispell
Lewistown
Missoula



Checkout the new CS Website



All four versions of Collaborative Stage are now presented on one page.

And, the natural order and alphabetical order are also available.

Easy to use!
Easy to organize!

<https://cancerstaging.org/cstage/schema/Pages/version0205.aspx>

Question and Answer

Question:

Radiation Therapy – Prostate: Is the regional treatment modality XRT best coded to 50 (brachytherapy, NOS), 53 (LDR) or 54 (HDR) when the documentation indicates only “I-125 seeds” to the prostate?

Answer:

Assign code 53 [Brachytherapy, interstitial, LDR] for seeds to the prostate. Seeds are always low dose because they are left in place and the radioactivity decays over time.

Source:

SEER Inquiry System, Question 20071125

Question:

Is malignant perivascular epithelioid cell tumor (PEComa) reportable?

Answer:

Assign histology code 8005/3 [malignant clear cell tumor]. According to our expert pathology consultant, this is the best histology code available at this time for the occasional tumor which is designated as malignant.

Source:

SEER Inquiry System, Question 20100024